SECTION A. GENERAL INFORMATION

The **State** of __Utah__ requests a waiver under the authority of Section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

Effective Dates: This waiver renewal is requested for a period of 2 years; effective __August 13, 2003__ and ending __August 12, 2005__.

The waiver program is called __Prepaid Mental Health Plan (PMHP)__.

State Contact: The State contact person for this waiver is __Julie Olson__ and can be reached by telephone at __(801) 538-6303__, or fax at __(801) 536-0156__, or e-mail at julieolson@utah.gov.

I. Statutory Authority

a. **Section 1915(b)(1):** The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which an enrollee can obtain medical care.

b. **Other Statutory Authority:** The State is also relying upon authority provided in the following section(s) of the Act:

1. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.IV.b Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list in Section A.IV.d.1 and Appendix D.III additional services to be provided under the waiver, which are not covered under the State plan. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval.

3. _X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

c. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act.

1. _X_ **Section 1902(a)(1)** - Statewideness–This Section of the Act requires a Medicaid State Plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2. ___ **Section 1902(a)(10)(B) -** Comparability of Services–This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. _X_ **Section 1902(a)(23) -** Freedom of Choice–This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO, PIHP, or PAHP.

4. _X_ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP.

5. ___ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their CMS Regional Office to identify required submission items from this format.

II. Background

(Required) Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder

involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

Executive Summary

The Division of Health Care Financing (DHCF), Utah's Medicaid agency, in the Utah Department of Health, administers the Medicaid program. Utah has been operating a waiver program called the Prepaid Mental Health Plan (PMHP) since July 1, 1991, in selected areas of the State. The current waiver renewal is to request continuation of the Utah Prepaid Mental Health Plan through August 2005. This waiver renewal contains an analysis of the two-year period from December 27, 2001 through December 26, 2003.

The overall objective of the PMHP is to maximize the contractors' flexibility to effectively and responsibly use Medicaid funds to ensure Medicaid clients have access to mental health services and to improve mental health outcomes for Medicaid clients.

During this waiver period, DHCF had contracts with nine community mental health centers (four urban and five rural) to provide all inpatient and outpatient mental health services to Medicaid enrollees, either directly or through arrangements with subcontractors. Approximately 98 percent of Utah Medicaid clients are enrolled in the PMHP.

All Medicaid clients, with the exception of individuals at the Utah State Hospital and the Utah Developmental Center, are automatically enrolled in the PMHP that serves their area. They are required to obtain covered mental health services from that contractor. As of July 1, 1995, children in State custody (foster care) are enrolled in the PMHP only for inpatient psychiatric services. They may receive outpatient mental health services from any qualified Medicaid provider.

Stakeholder Involvement–DHCF has put in place a stakeholders' group for the purpose of collaborating and coordinating on an ongoing basis with representatives from advocacy groups (e.g., Utah Alliance for the Mentally Ill and parent advocacy groups, etc.) and other agencies that serve populations with mental health needs that are also served by the PMHP. The State seeks input from this group on the relevant operational and monitoring issues of the Prepaid Mental Health Plan.

The State also participates in other established councils designed to ensure children (Medicaid and non-Medicaid) receive needed mental health services. The State serves as a member of the Children's Mental Health Advisory Council and the Children's Mental Health Coordinators committee. Both of these forums provide a mechanism for identifying and addressing PMHP-related issues.

CONCLUSIONS: The State has demonstrated that the Utah Prepaid Mental Health Plan continues to be cost-effective and recipients' access to quality mental health care has not been impaired under the waiver. The State will continue its monitoring efforts to ensure continued cost-effectiveness and access to services of adequate quality under the current waiver that restricts Medicaid enrollees in certain counties of the state to a contracting mental health plan.

III. General Description of the Waiver Program

a. **Type of Delivery Systems:** The State will be entering into the following types of contracts with an MCO, PIHP, or PAHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g., a PIHP program for a mental health carve-out is "other risk," but just checking the relevant items under "2" will not convey that information fully. Please note this answer should be consistent with your response in Section A.IV.d.1 and Section D.I.

1. ___**Risk-Comprehensive (fully-capitated–MCOs or HIOs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

   (a) ___ The contractor is at-risk for inpatient hospital services and any one of the following services:

      i. ___ Outpatient hospital services,
      ii. ___ Rural health clinic (RHC) services,
      iii. ___ Federally qualified health clinic (FQHC) services,
      iv. ___ Other laboratory and X-ray services,
      v. ___ Skilled nursing facility (NF) services,
      vi. ___ Early Periodic screening, diagnosis, and treatment (EPSDT) services,
      vii. ___ Family planning services;
      viii. ___ Physician services, and
      ix. Home health services.

   (b) ___ The contractor is at-risk for three or more of the above services (i)\ through (ix). Please mark the services in (a) and list the services in Section A.IV.d.1.

2. __X__ **Other Risk (PIHP/PAHP):** Other risk contracts are those that have a scope of risk that is less than comprehensive. The contractors in these programs are either PIHPs or PAHPs (e.g., a PIHP for mental health/substance abuse). References in this preprint to PIHPs/PAHPs generally apply to these other risk entities. For PIHPs, please check either (a) or (b); if (b) is chosen, please check the services that apply. For PAHPs, please check (b), and indicate the services that apply.

   (a) ___ The contractor is a PIHP at-risk for all inpatient hospital services.

   or

   (b) __X__ The contractor is a PIHP or PAHP at-risk for two or fewer of the below services (i) through (x).

   i. ___ Outpatient hospital services;
   ii. ___ Rural health clinic (RHC) services;
   iii. ___ Federally qualified health clinic (FQHC) services;
   ix. ___ Other laboratory and X-ray services;
   v. ___ Skilled nursing facility (NF) services;
   vi. ___ Early periodic screening, diagnosis, and treatment EPSDT) services;
   vii. ___ Family planning services;
   viii. ___ Physician services;
   ix. ___ Home health services;
   x. __X__ Other:
   ___ dental
   ___ transportation
   __X__ a subset of inpatient hospital services (e.g., only mental health admissions)

3. **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., a PIHP contract where the State performs a cost-settlement process at the end of the year.) If this block is checked, replace Section D (Cost-Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4. Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly).

b. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to CMS):

1. ___ Statewide–all counties, zip codes, or regions of the State have managed care (please list in the table below) or

2. **X** Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, in the chart below please list the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PIHP, PAHP, HIO, or other entity) with which the State will contract:

Counties	**Name of Entity***	**Type of Entity**
Box Elder, Cache, Rich	Bear River Mental Health	PIHP
Juab, Millard, Sanpete, Sevier, Piute, Wayne	Central Utah Mental Health	PIHP
Davis	Davis Behavioral Health	PIHP
Carbon, Emery, Grand	Four Corners Community Behavioral Health	PIHP
Beaver, Garfield, Iron, Kane, Washington	Southwest Center	PIHP
Salt Lake, Summit, Tooele	Valley Mental Health	PIHP
Utah**	Wasatch Mental Health	PIHP
Morgan and Weber	Weber Mental Health	PIHP
Duchesne, Daggett, Uintah	Northeastern Counseling Center	PIHP

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every county listed here as described in Section D.

Effective July 1, 2003 Wasatch County (which was part of Wasatch Mental Health in the last waiver period) will no longer be included in the Prepaid Mental Health Plan, but will provide mental health services on a fee-for-service basis. The map in **Attachment A.III.b.2 portrays the Prepaid Mental Health Plan areas.

c. **Requirement for Choice:** Section 1932(a)(3) of the Act and 42 CFR 438.52 require the State to permit individuals to choose from not less than two managed care entities.

1. ___ This model has a choice of managed care entities.
   (a) ___ At least one MCO and PCCM (Please use the combined PCCM Capitated Waiver Renewal Preprint);
   (b) ___ One PCCM system with a choice of two or more Primary Care Case Managers (Please use the PCCM Waiver Renewal Preprint);
   (c) ___ Two or more MCOs;
   (d) ___ At least one PIHP or PAHP and a combination of the above entities;

2. ___ This model is an HIO.

3. ___ The State is opting to use the exception for rural area residents in Section 1932(a)(3) and 42 CFR 438.52(b). Please list the areas of the State in which the rural exception applies.

4. **X** The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP.

d. **Waiver Population Included:** The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1. **X** Section 1931 Children and Related Poverty-Level Populations (TANF);

2. **X** Section 1931 Adults and Related Poverty-Level Populations, including pregnant women (TANF);

3. **X** Blind/Disabled Children and Related Populations (SSI);

4. **X** Blind/Disabled Adults and Related Populations (SSI);

5. **X** Aged and Related Populations:

   (SSI, QMB dually-eligible Medicare and Medicaid);

6. **X** Foster Care Children (enrolled for inpatient psychiatric care only);

7. ___ Title XXI SCHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected

the State Children's Health Insurance Program through Medicaid;

8. **X** Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.
    - Individuals who qualify for Medicaid by paying a spenddown and are under age 19;
    - Pregnant women (non-TANF).

9. ___ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

    (a) ___ Children with special needs due to physical and/or mental illness;
    (b) ___ Older adults;
    (c) ___ Foster care children;
    (d) ___ Homeless individuals;
    (e) ___Individuals with serious and persistent mental illness and/or substance abuse;
    (f) ___Non-elderly adults who are disabled or chronically ill with developmental or physical disability; or
    (g) ___ Other (please list):

e. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. ___ Have Medicare coverage, except for purposes of Medicaid-only services;

2. ___ Have medical insurance other than Medicaid;

3. ___ Are residing in a nursing facility;

4. ___ Are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5. ___ Are enrolled in another Medicaid managed care program;

5. Have an eligibility period that is less than three months;

7. ___ Are in a poverty-level eligibility category for pregnant women;

8. ___ Are American Indian or Alaskan Native;

9. Participate in a home and community-based waiver;

10. **X** Receive services through the State's Title XXI CHIP program;

11. ___ Have an eligibility period that is only retroactive;

12. **X** Are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);

    (a) ___ Children with special needs due to physical and/or mental illnesses;
    (b) ___ Older adults;,
    (c) **X** Foster care children (outpatient only);
    (d) ___ Homeless individuals;
    (e) ___ Individuals with serious and persistent mental illness and/or substance abuse;
    (f) ___ Non-elderly adults who are disabled or chronically ill with development or physical disability, or
    (g) **X** Other (Please list):

    - Individuals residing in Utah State Hospital and Utah Developmental Center;
    - Section 1931 adults age 19 and older and related poverty-level populations;
    - All individuals who live in counties excluded from the waiver;
    - Individuals age 19 and older who qualify for Medicaid by paying a spenddown.

13. ___ Have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

f. **Automated Data Processing:** Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

g. **Independent Assessment:** The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to CMS at least three months prior to the end of the waiver period.** [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. ___ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.

2. **X** Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

IV. Program Impact

In the following informational sections, please complete the required information to describe your program.

a. **Marketing** including indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general) and direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). *Information to potential enrollees and enrollees (i.e., member handbooks), is addressed in Section H.*

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]
Please describe how often and through what means the State monitored compliance with its marketing requirements, as well as results of the monitoring. [Reference: items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint, or items A.III.a Upcoming Waiver Period of 1999 Waiver Renewal preprint].

Because enrollment in the PMHP is mandatory, marketing is not applicable. However, information is given to enrollees regarding the PMHP and the contractor with whom they are enrolled. At the time of Medicaid enrollment, enrollees are given a PMHP brochure, an *Exploring Medicaid* booklet, and a *Speak Up for Yourself –You will get Better Health Care* booklet.

Exploring Medicaid is a Medicaid booklet which is written in two versions—one urban and one rural. The booklet describes services covered under Medicaid including mental health services covered under the PMHP. An urban and rural version of *Speak up for Yourself* is also distributed to Medicaid clients. This booklet contains information to help the enrollee be more assertive in order to obtain better health care, including services from the PMHP. These booklets are available in both English and Spanish.

Upcoming Waiver Period – Please describe the waiver program for the upcoming two-year period.

1. **X** The State does not permit direct or indirect MCO/PIHP/PAHP marketing (go to item "b. Enrollment/Disenrollment").

2. ___ The State permits indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general). Please list types of indirect marketing permitted.

3. ___ The State permits direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Request for Proposals, if applicable.

4. ___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

5. ___ The State permits MCOs/PIHPs/PAHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6. ___ The State requires MCO/PIHP/PAHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

   The State has chosen these languages because (check those that apply):
   (a) The languages comprise all prevalent languages in the MCO/PIHP/PAHP service area.
   (b) ___ The languages comprise all languages in the MCO/PIHP/PAHP service area spoken by approximately ___ or more of the population.
   (c) ___ Other (please explain):

7. ___The State requires MCO/PIHP/PAHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **Required Marketing Elements:** Listed below is a description of requirements that the State must meet under the waiver program (items a through g). If an item is not checked, please explain why.

The State:

(a) ___ Ensures that all marketing materials are prior approved by the State;

(b) ___ Ensures that marketing materials do not contain false or misleading information;

(c) ___ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of marketing materials;

(d) ___ Ensures that the MCO/PIHP/PAHP distributes marketing materials to its entire service area;

(e) ___ Ensures that the MCO/PIHP/PAHP does not offer the sale of any other type of insurance product as an enticement to enrollment;

(f) ___ Ensures that the MCO/PIHP/PAHP does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing;

(g) ___ Ensures that the MCO/PIHP/PAHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services;

b. Enrollment/Disenrollment

Previous Waiver Period

[Required for all elements checked in the previous waiver submission]
Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements. Please include the results from those monitoring efforts for the previous waiver period.(Reference items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint; items A.III.b Upcoming Waiver Period of 9/23/99 Waiver Renewal).

Enrollment is mandatory for populations specified in A.III.d. Enrollees are automatically enrolled in the PMHP if they live in one of the counties covered under the waiver and are not in a group excluded from participation in the waiver as specified in A.III.e.

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs/PIHPs/PAHPs by checking the applicable items below.

1. ___ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out-stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program.

2. ___ Administration of Enrollment Process:

(a) **_X_** State staff conduct the enrollment process;

Since the authorization for the contract is based on a freedom-of-choice waiver which restricts Medicaid enrollees living in specific counties to obtain mental health services from a mental health center under contract with the Department, the Department will automatically enroll any Medicaid-eligible person who is determined by PACMIS to reside in the catchment area covered by the contractor.

(b) ___The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request the authority in 1915(b)(2) in Section A.I.b.1. (Refer to Section 2105 of the State Medicaid Manual);

i. Broker name:
ii. Procurement method:
(A). ___ Competitive
(B). ___ Sole Source
iii. Please list the functions that the contractor will perform:

(c) ___ State allows MCOs/PIHPs/PAHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. Enrollment Requirement: Enrollment in the program is:

(a) **_X_** Mandatory for populations in Section A.III.d.

(b) ___ Voluntary - See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(b) ___ Other (please describe):

4. Enrollment

(a) ___ The State will make counseling regarding their MCO/PIHP/PAHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b) ___ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCOs/PIHPs/PAHPs and providers based on their medical needs. Please describe.

(c) ___ Enrollees will notify the State/enrollment broker of their choice of plan by:

i. ___ mail
ii. ___ phone
iii. ___ in person at
iv. ___ other (please describe)

(d) **X** **[**Required] There will be an open enrollment period during which the MCO/PIHP/PAHP will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

Since the enrollment is mandatory for this plan, an open enrollment period is not applicable.

(e) ___ Newly-eligible beneficiaries will receive initial notification of the requirement to enroll in the program. Please describe the initial notification process.

(f) ___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g) ___ If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. ___ Potential enrollees will have ___ days/month(s) to choose a plan.
ii. ___ Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-

assignment process assign persons with special health care needs to an MCO/PIHP/PAHP that includes their current provider or to an MCO/PIHP/PAHP that is capable of serving their particular needs?

(h) ___ The State provides guaranteed eligibility of ___ months for all MCO enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i) **_X_** The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

The State allows enrollees in subsidized adoption aid categories to be exempted or disenroll from the outpatient portion of the PMHP on a case-by-case basis when requested by parents. Legislation was passed in Utah's 2001 general legislative session that allows subsidized adoptive children to receive mental health services outside of the capitated system. These exempted children, like foster care children, remain enrolled in the PMHP for inpatient psychiatric care only. They may receive outpatient mental health services from any qualified Medicaid provider.

5. Disenrollment:

(a) ___ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs.

i. ___ Enrollee submits request to State

ii. ___ Enrollee submits request to MCO/PIHP/PAHP. The plan may approve the request, or refer it to the State. (The plan may not disapprove the request).

iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP grievance procedure before determination will be made on disenrollment request

iv. ___ [Required] Regardless of whether plan or State makes determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

(b) ___ The State does not allow enrollees to disenroll from the only available PIHP/PAHP.

(c) ___ The State monitors and tracks disenrollments and transfers between MCOs/PIHPs/PAHPs. Please describe the tracking and analysis:

(d) ___ The State has a lock-in period of ___ months (up to 12 months permitted). If so, the following are required:

i. ___ MCO/PIHP/PAHP enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO/PIHP/PAHP.

ii. ___ MCO/PIHP/PAHP enrollees must be notified of their ability to disenroll or change MCOs/PIHPs/PAHPs at the end of their enrollment period at least 60 days before the end of that period.

iii. ___ MCO/PIHP/PAHP enrollees who have the following "good cause" reasons for disenrollment are allowed to disenroll during the lock-in period:

A. ___ [Required] Enrollee moves out of plan area;
B. [Required] Plan does not, because of moral or religious objections, cover the service the enrollee seeks;
C. ___ [Required] Enrollee needs related services; not all services available in network, and enrollee's provider determines that receiving services separately would subject enrollee to unnecessary risk;
D. ___ [Required] Poor quality of care;
E. ___ [Required] Lack of access to covered services;
F. ___ [Required] Lack of access to providers experienced in dealing with enrollee's health care needs;
G. ___ Other: (please list).

iv. [Required] Ensure access to State fair hearing process for any enrollee dissatisfied with determination that there is not good cause for disenrollment.

(e) ___ The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs are allowed to terminate or change their enrollment without cause at any time.

(f) ___ [Optional] A beneficiary who is disenrolled from an MCO/PIHP/PAHP solely due to loss of eligibility for two months or less may be automatically re-enrolled with the same MCO/PHIP/PAHP.

6. MCO/PIHP/PAHP Disenrollment of Enrollees: If the State permits MCOs/PIHPs/PAHPs to request disenrollment of enrollees, please check items below that apply:

(a) ___ [Required] The MCO/PIHP/PAHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is discriminatory in any way–including adverse change in an enrollee's health status, utilization of medical services, diminished mental capacity, and non-compliant behavior for individuals with mental health and substance abuse diagnoses–against the enrollee. Please describe the reasons for which the MCO/PIHP/PAHP can request reassignment of an enrollee:

(b) ___The State reviews and approves all MCO/PIHP/PAHP-initiated requests for enrollee transfers or disenrollments.

(c) ___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHHP/PAHP to remove the enrollee from its membership.

(d) ___ The enrollee remains a member of the MCO/PIHP/PAHP until another MCO/PIHP/PAHP is chosen or assigned.

c. Entity Type or Specific Waiver Requirements

Upcoming Waiver Period – Please describe the entity type or specific waiver requirements for the upcoming two-year period.

1. _X_ Required MCO/PIHP/PAHP Elements: MCOs/PIHPs/PAHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR Parts 434 and 438 et seq.

2. Required Elements Relating to Waiver under Section 1915(b)(4): If the State is requesting authority under Section 1815(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a) **_X_** The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i. **X** Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in the State's Medicaid State Plan.

ii. **X** MCO/PIHP/PAHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii. **X** MCO/PIHP/PAHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv. **X** Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long-term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. **X** There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has selected/will select the MCOs/PIHPs/PAHPs that will operate under the waiver in the following manner:

(a) **X** The State has used/will use a competitive procurement process. Please describe.

The State used a competitive or open procurement process during the initial waiver development.

Request for Proposal: In 1990, the Division of Health Care Financing issued a Request for Proposal (RFP) requesting proposals from any entity that could provide the full array of covered services under the waiver either directly or through subcontracts. The six proposals that met the RFP requirements were all community mental health centers. Final agreements were negotiated with three of the six community mental health centers. These three contractors–Four Corners Mental Health, Southwest Mental Health, and Valley Mental Health, have been participating in the program since that time.

Formal Solicitation of Participation in a Prepaid Mental Health Plan: In keeping with legislative intent to expand the network of managed care providers in the Medicaid program, the program was expanded to other areas of the state. In February 1994, the Division of Health Care Financing received approval from the State Division of Purchasing to enter into other sole source contracts with local county mental health authorities and their designated mental health providers for the scope of Medicaid services to be provided under the PMHP. This was justified on the basis that the local county mental health authorities control the state and county dollars that support the outpatient mental health services provided under the PMHP contracts. To determine which of the community mental health centers were interested and capable of delivering care under a managed care system, in February 1995, the Division of Health Care Financing issued its "Formal Solicitation for Participation in the Prepaid Mental Health Plan" to the remaining eight community mental health centers.

Of the eight centers, five responded. They appeared capable of meeting client needs and required assurances. Contract negotiations were begun in April 1995, and the Division of Health Care Financing entered into contracts with these five centers–Bear River Mental Health, Weber Mental Health, Wasatch Mental Health, Davis Behavioral Health, and Central Utah Mental Health, effective July 1, 1995.

The State contracted with Northeastern Counseling Center, effective January 1, 2002, one of the two remaining fee-for-service mental health centers, as a PMHP contractor. The center responded to the "Formal Solicitation for Participation in the Prepaid Mental Health Plan" and met the requirements of the solicitation.

Contractors offer choice of provider within the plan and have the flexibility to subcontract with other community providers.

(b) ___ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PIHP/PAHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c) ___ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a

manner to provide to the maximum extent practical, open and free competition.

4. ___ Per Section 1932(d) of the Act and 42 CFR 438.58, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO/PIHP/PAHP contracts and the default enrollment process established for MCOs/PIHPs/PAHPs.

c. Services

Previous Waiver Period

[Required for all elements checked in the previous waiver submission] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. Please include the results from those monitoring efforts for the previous waiver period. [Reference:

items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint, items A.III.d Upcoming Waiver Period of 9/23/99 Waiver Renewal Preprint]

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved by CMS as part of the two-year waiver extension. To evaluate compliance with this monitoring plan, the Division of Health Care Financing conducted onsite visits to each PMHP contractor during the waiver period and monitored to specific objectives contained in this monitoring plan that had been agreed upon by CMS. See the attached copy of the State's Operating and Monitoring Plan V and the results of the Division of Health Care Financing's monitoring during this waiver period in **Attachment A.IV.d.1. (Previous Waiver Period).**

Upcoming Waiver Period – Please describe the service-related requirements for the upcoming two-year period.

1. **X** The Medicaid services MCOs/PIHPs/PAHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's State Plan are or are not in the MCO/PIHP/PAHP contract; (i.e., for calculating cost-effectiveness; see Appendix D.III); and which new non-State Plan services are available only through the MCO/PIHP/PAHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver;
- subset(s) of State Plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services;
- services not covered by the State Plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services).

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost-effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) Waiver Services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PIHP/PAHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PIHP/PAHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PIHP/PAHP; i.e., not included in the reimbursement paid to the MCO/PIHP/PAHP. However, do not include services impacted by the MCO/PIHP/PAHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement Impacted by MCO/PIHP/PAHP: Check this column if the service is not the responsibility of the MCO/PIHP/PAHP, but is impacted by it. For example, if the MCO/PIHP/PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PIHP/PAHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-for-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PIHP/PAHP (see column 5).

Note: Each service should have a mark in columns 2 and 4 or 5.

Service (1)	**State Plan Approved (2)**	**MCO/PIHP/ PAHP Capitated Reimbursement (4)**	**FFS Reimbursement (5)**	**FFS Reimbursement Impacted by MCO/PIHP/ PAHP (6)**
Day Treatment Services	X			
Dental	X			
Detoxification	X			
Durable Medical Equipment	X			
Emergency Services	X	X		
EPSDT	X			
Federally Qualified Health Center Services	X	X		
Home Health	X			
Hospice	X			
Inpatient Hospital – Psychiatric	X			
Inpatient Hospital – Psychiatric	X			
Inpatient Hospital - Other	X	X		
Immunizations	X			
Lab and X-ray	X			
Mental Health Services (please refer to page 25, 26 A.IV.d)	X	X		
Nurse Midwife	X			
Nurse Practitioner	X			
Nursing Facility	X			
Obstetrical Services	X			

Occupational Therapy	X			
Other Fee-for-Service Services	X			
Other Psych Service	X			
Outpatient Hospital-All Other	X			
Outpatient Hospital-Lab and X-ray	X			
Personal Care	X			
Pharmacy	X			X
Physical Therapy	X			
Physician	X	X		
Private Duty Nursing	X			
Prof. & Clinic and Other Lab & X-ray	X			
Psychologist	X	X		
Rural Health Clinic	X			
Speech Therapy	X			
Substance Abuse Treatment Services	X			
Testing for Sexually-transmitted Diseases (STDs)	X			
Transportation – Emergency	X			
Transportation - Non-Emergency	X	X		
Vision Exams and Glasses	X			
Other–please specify 1915(c) services	X			
Audiology	X			
Chiropractic Services	X			
Dialysis	X			

Diabetes Self-Mgmt. Education	X			
Early Intervention	X			
Enhanced Services to Pregnant Women	X			
Podiatry	X			
Targeted Case Management	X	X		
Other Inpatient Services–please specify				

Upcoming Waiver Period– Please describe the service-related requirements for the upcoming two-year period.

The services covered under the PMHP contracts have not changed since implementation of the waiver on July 1, 1991. The PMHP contractors are required to provide, at a minimum, all appropriate services in accordance with the scope of services in the *Utah State Plan* and the *Utah Medicaid Mental Health Centers Provider Manual*. These services include:

- Inpatient psychiatric hospital and related physician services based on the following International Classification of Diseases (ICD-9): 295 through 302, 306 through 309, 311 through 314 and 316;

- Outpatient mental health services including:

  - Mental health evaluation;
  - Psychological testing;
  - Individual mental health therapy;
  - Group mental health therapy;
  - Individual behavior management;
  - Group behavior management;
  - Medication Management;
  - Skills development services;
  - Targeted case management for chronically mentally ill adults and seriously emotionally disturbed children who need case management services and are not otherwise receiving similar services under another program authority, unless mutually agreed to by the PMHP contractor and the Medicaid agency; and

- Transportation to needed mental health services, but not including public transit systems such as the Utah Transit Authority.

2. Emergency Services: [Required] The State must ensure enrollees in MCOs/PIHPs/PAHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(a) ___ The State has a more stringent definition of emergency medical condition for MCOs/PIHPs/PAHPs than the definition above. Please describe.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b) **X** The State ensures enrollee access to emergency services by requiring the MCO/PIHP/PAHP to provide adequate information to all enrollees regarding emergency service access (See Section H--Enrollee Information and Rights).

(c) **X** The State ensures enrollee access to emergency services by including in the contract with MCOs/PIHPs/PAHPs a requirement to cover and pay for the following: *Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs/PAHPs the flexibility to develop their own payment mechanisms; e.g., separate fee for screen/evaluation and stabilization, bundled payment for both, etc.*

i. **X** For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PMHP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met;

ii. **X** The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition;

iii. **X** Subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient;

iv. **X** Continued emergency services until the enrollee can be safely discharged or transferred;

v. **X** Post-stabilization services which are pre-authorized by the MCO/PIHP/PAHP, or were not pre-authorized, but the MCO/PIHP/PAHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP/PAHP contacts the emergency room and takes responsibility for the enrollee.

(d) The State also assures the following additional requirements are met:

i. **X** The MCO/PIHP/PAHP may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms;

ii. **X** The MCO/PIHP/PAHP may not refuse to cover emergency services based on the provider not notifying the enrollee's PMHP or plan of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;

iii. **X** The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is

(e) ___ The MCO/PIHP/PAHP does not cover emergency services.

3. Family Planning: In accordance with 42 CFR 431.51(b), pre-authorization by the enrollee's PMHP (or other MCO/PIHP/PAHP staff), or requiring the

use of participating providers for family planning services is prohibited under the waiver program.

(a) ___ Enrollees are informed that family planning services will not be restricted under the waiver.

(b) ___ Non-network family planning services are reimbursed in the following manner:

i. ___ The MCO/PIHP/PAHP will be required to reimburse non-network family planning services.

ii. ___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers.

iii. ___ The State will pay for all family planning services, provided by both network as well as non-network providers.

iv. ___ The State pays for non-network services and capitated rates were set accordingly.

v. ___ Other (please explain):

(c) **_X_** Family planning services are not included under the waiver.

4. Other Services to Which Enrollee Can Self-Refer: In addition to emergency care and family planning, the State requires MCOs/PIHPs/PAHPs to allow enrollees to self-refer (i.e., access without prior authorization) under the following circumstances or to the following services:

(a) ___ [Required for rural exception to choice]

- The service or type of provider is not available in the plan;
- For up to 60 days if provider is not part of the network but is the main source of care and is given opportunity to join network but declines;
- MCO/PIHP/PAHP or provider does not, because of moral or religious objections, provide a covered service; provider

determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.

(b) ___ [Required if women's routine and preventive care is a covered service] Female enrollees must have direct access to women's health specialist within the network for covered care related to women's routine and preventive care. (Please note whether self-referral is allowed only to network providers or also to non-network providers.)

(d) Other: (please identify).

5. Monitoring Self-Referral Services: The State places the following requirements on the MCO/PIHP/PAHP to track, coordinate, and monitor services to which an enrollee can self-refer:

At the time of initial eligibility into the Medicaid program, Health Program Representatives (HPRs) of Bureau of Eligibility Services (BES) workers employed by the Medicaid agency, explain all services covered under Medicaid to Medicaid eligibles. Medicaid eligibles can access services not covered under the PMHP waiver (e.g., physical health services, home and community-based waiver services, pharmacy services, long-term care services, etc.) in the same manner as under the regular Medicaid program or under the Choice of Health Care Delivery waiver program.

6. Federally Qualified Health Center: (FQHC) services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a) ___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP is not required to provide FQHC services to the enrollee during the enrollment period.

(b) **X** The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PIHP/PAHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP he or she

selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP with a participating FQHC:

All of the PMHPs have an FQHC in their catchment area. Consequently, the PMHP contract requires the contractors to attempt to subcontract with the FQHC in their area. Also, clients on an individual basis can request authorization from the PMHP contractor to receive services from the FQHC.

(c) ___ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) ___ The State requires MCOs/PIHPs/PAHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

(b) ___ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: CMS requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the CMS 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c) ___ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

(d) ___ Immunizations are covered under the waiver, and managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e) ___ Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP/PAHP. Please describe and clarify the aspects of school services that are coordinated including IEPs, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

(f) **X** Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc.) with those provided by the MCO/PIHP/PAHP. Please describe.

The PMHP contract contains the following provision regarding EPSDT services:

The contractor shall comply with the requirements of OBRA 1989 legislation regarding services for children under age 21 who have had a Child Health Evaluation and Care (CHEC) screening. Section 1396d(r) of the 42 USC requires that states provide all services that are medically necessary to correct or ameliorate defects and physical or mental illnesses and conditions discovered through the Early Periodic Screening Diagnostic and Treatment (EPSDT) program. (EPSDT is called the CHEC program in Utah). The contractor agrees to provide all covered services when they are medically necessary and one of the following conditions is met:

1. As a result of a CHEC exam (conducted by an HMO or fee-for-service physician), it is found that further diagnostic services are needed to determine the existence of a mental illness or condition; or

2. It is determined that a mental health service may be necessary to correct or ameliorate a mental illness or condition, or prevent deterioration of that condition or the

development or additional health problems.
PMHP case managers may assist EPSDT-eligible children to obtain other needed services (dental, medical, social, educational, etc.) as needed.

PMHP staff also participated as members of Local Interagency Councils (LICs) where children with multiple and complex needs are staffed. LICs are comprised of representatives from the mental health center (PMHP), the local schools, juvenile court, Division of Child and Family Services, Division of Youth Corrections, Division of Services for People with Disabilities, and the local health department.

Children (Medicaid and non-Medicaid) were referred to the LIC by these agencies. Children were referred because they have complex needs requiring interventions and coordinated services from multiple agencies. The LIC "staffed" the child and developed a comprehensive service plan that included services from some of these agencies. Services were targeted not only to the child, but also to his/her family when needed. Schools often were the primary LIC referral source. The LICs provided an excellent mechanism for the PMHPs to coordinate provision of mental health services with the other agencies (including the schools) that were also providing needed services.

SECTION B. ACCESS AND CAPACITY

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residences of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services, and access to emergency and family planning services must not be restricted.

I. Timely Access Standards

Upcoming Waiver Period – Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards:** The State has established maximum distance and/or travel time requirements, given clients' normal means of transportation, for MCO/PIHP/PAHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1. ___ PCPs (please describe your standard):

2. ___ Specialists (please describe your standard):

3. ___ Ancillary providers (please describe your standard):

4. ___ Pharmacies (please describe your standard):

5. ___ Hospitals (please describe your standard):

6. **X** Mental health (please describe your standard):

   The standard is that PMHPs have services available in every county. Contractors either have a major clinic or satellite clinic in every county; or in the more frontier-type counties, they have a clinician(s) who travels to that county a specified number of days per week/month to provide services. In addition, as per the PMHP contract , the contractor will make services available at locations and times to accommodate enrollees including homeless individuals, and those who are unable to get to clinic locations during normal working hours, etc.

7. ___ Substance abuse treatment providers (please describe your standard):

8. ___ Dental (please describe your standard):

9. ___ Other providers (please describe your standard):

b. Appointment Scheduling: (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1. ___ PCPs (please describe your standard):

2. ___ Specialists (please describe your standard):

3. ___ Ancillary providers (please describe your standard):

4. ___ Pharmacies (please describe your standard):

5. ___ Hospitals (please describe your standard):

6. **X** Mental health (please describe your standard):

The contractor will provide timely covered services in accordance with he following time frames to enrollees not currently served by the contractor but who seek services:

(a) If based on the initial contact it appears the enrollee has an emergency, the contractor will respond to the enrollee within 30 minutes. If the contractor determines that the enrollee has an emergency, the contractor will provide face-to-face emergency services within one hour or within a time frame mutually agreed on by the enrollee or his or her agent and the contractor.

(b) If it is determined during the initial contact that the enrollee requires urgent care, the contractor will provide face-to-face covered services within a maximum of five working days of the initial contact. The contractor will also provide appropriate information regarding emergency services to the enrollee with instructions to contact the contractor if more immediate services are needed.

(c) If it is determined during the initial contact that the enrollee requires non-urgent care, the contractor will provide face-to-face covered services within 15 working days of the initial contact.

7. ___ Substance abuse treatment providers (please describe your standard):

8. ___ Dental (please describe your standard):

9. ___ Urgent care (please describe your standard):

10. ___ Other providers (please describe your standard):

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1. ___ PCPs (please describe your standard):

2. ___ Specialists (please describe your standard):

3. ___ Ancillary providers (please describe your standard):

4. ___ Pharmacies (please describe your standard):

5. ___ Hospitals (please describe your standard):

6. ___ Mental health (please describe your standard):

7. ___ Substance abuse treatment providers (please describe your standard):

8. ___ Dental (please describe your standard):

9. ___ Other providers (please describe your standard):

II. Access and Availability Monitoring: Enrollee access to care will be monitored by the State, as part of each MCO/PIHP/PAHP's Quality Assessment and Performance Improvement program, annual external quality review (EQR), and (if applicable) Independent Assessments (IA).

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]

Please include the results from monitoring MCO/PIHP/PAHP access and availability in the previous two-year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint; item B.II Upcoming Waiver Period, 9/23/99 Waiver Renewal Preprint].

Please refer to Objective 1.1 and 3. 1 of the Operating and Monitoring Plan V in **Attachment A.IV.d.1 (Previous Waiver Period).** The State monitored Objective 1.1 while conducting its onsite reviews. The Contractors submitted semi-annual complaint summaries to meet the requirements under Objective 3.1. In the complaint summaries, contractors summarized complaints according to type of complaint: access-related, quality-related and other. By grouping complaints this way, contractors can evaluate the number of access-related complaints and determine the extent of the problem. Contractors also report on resolutions and whether complaints were resolved. Access complaints are therefore an indicator of access issues. The contractors' complaint summaries and the State's analyses are found in **Attachment B.II (Previous Waiver Period).**

Upcoming Waiver Period – Check below any of the following (a-o) that the State will also utilize to monitor access:

a. ___ Measurement of access to services during and after an MCO/PIHP/PAHP's regular office hours to assure 24-hour accessibility, seven days a week (e.g., PCP's 24-hour accessibility will be monitored through random calls to PCPs during regular and after-office hours);

b. ___ Determination of enrollee knowledge on the use of managed care programs;

c. **X** Ensure that services are provided in a culturally competent manner to all enrollees, and the MCO/PIHP/PAHP participates in any State efforts to promote the delivery of services in a culturally competent manner;

d. ___ Review of access to emergency or family planning services without prior authorization;

e. ___ Review of denials of referral requests;

f. Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care;

g. Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a

sample of enrollees. Corrective actions taken on deficiencies found are also planned;

h. ___ Measurement of enrollee requests for disenrollment from an MCO/PIHP/PAHP due to access issues;

i. **X** Tracking of complaints/grievances concerning access issues;

In the upcoming waiver period contractors will report on grievances and appeals.

j. ___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluate network adequacy. (Please explain);

k. ___ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies;

l. ___ During monitoring, the State will look for the following indications of access problems:

1. ___ Long waiting periods to obtain services from a PCP;
2. ___ Denial of referral requests when enrollees believe referrals to specialists are medically necessary;
3. ___ Enrollee confusion about how to obtain services not covered under the waiver;
4. ___ Lack of access to services after PCP's regular office hours;
5. ___ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care;
6. ___ Lack of access to emergency or family planning services;
7. ___ Frequent recipient requests to change a specific PCP;
8. ___ Other indications (please describe):

m. ___ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically-necessary mental health services;

n. **X** Monitoring the provider network showing that there will be providers within the distance/travel times standards;

(See B.I.a.6.).

o. The incentives, sanctions, and enforcement related to the access and availability standards above;

p. ___ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a. **X** [Required] MCO/PIHP/PAHP Capacity Standards. The State ensured that the number of providers under the waiver remained adequate to assure access to all services covered under the contract. Please describe the results of this monitoring.

The State requires contractors to submit encounter data. From the encounter data, penetration rates are tracked across fiscal years to ensure they remain consistent. Consistent penetration rates are an indicator or proxy that the number of providers remains the same over time.

b. ___ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submission] The State has monitored to ensure that enrollment limits and open panels were adequate. Please describe the results of this monitoring.

Upcoming Waiver Period – Please describe the capacity standards for the upcoming two-year period.

a. MCO/PIHP/PAHP Capacity Standards

1. ___ The State has set enrollment limits for the MCO/PIHP/PAHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2. ___ The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP. Please describe how often and how the monitoring takes place.

3. **X** **[**Required**]** The State ensures that the number of providers under the waiver is adequate to assure access to all services covered under the contract. Please describe how the State will ensure that provider capacity will be adequate.

The contract between the Division of Health Care Financing and the PMHPs requires the contractors to have sufficient capacity to provide needed services. The contract states that the contractor shall provide the

Department and the Centers for Medicare and Medicaid Services (CMS) adequate assurances that the contractor, with respect to the service area, has the capacity to provide needed services, including assurances that the contractor offers an appropriate range of services and maintains a sufficient number, mix, and geographic distribution of providers of services.

The contract further states that if the contractor does not have sufficient capacity to provide needed services directly, the contractor must ensure needed services are available timely by subcontracting with other provider(s) that offer the same level of care.

Using encounter data, the State will continue to track penetration rates on a fiscal-year basis to ensure they remain the same or increase as a measure of adequate numbers of providers.

b. PCP Capacity Standards

1. ___ The State has set capacity standards for PCPs within the MCO/PIHP/PAHP expressed in the following terms (In the case of a PIHP/PAHP, a PCP may be defined as a case manager or gatekeeper):

   (a) ___ PCP-to-enrollee ratio;
   (b) ___ Maximum PCP capacity;
   (c) ___ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans.

2. The State ensures adequate geographic distribution of PCPs within MCO/PIHP/PAHPs. Please explain:

3. ___ The State designates the type of providers that can serve as PCPs. Please list these provider types.

c. Specialist Capacity Standards

1.___ The State has set capacity standards for specialty services. Please explain:

2. **X** The State requires particular specialist types to be included in the MCO/PIHP/PAHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard, if applicable; e.g., specialty-to-

enrollee ratio. If specialist types are not involved in the MCO/PIHP/PAHP network, please describe how arrangements are made for enrollees to access these services (for waiver-covered services only).

Specialist Provider Type	Adult	Children
Physicians/APRNs	X	X
RNs/LPNs	X	X
Licensed mental health therapists (not including physicians)	X	X
Other licensed staff such as CSWs and SSWs who are not licensed mental health therapists, and case managers who are not licensed as one of the above	X	X

IV. Capacity Monitoring

Previous Waiver Period

a. **X** [Required for all elements checked in the previous waiver submission] Please include the results from monitoring the MCO/PIHP/PAHP capacity in the previous two-year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint; item B.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

Please refer to Objective 3. 1 of the Operating and Monitoring Plan V in **Attachment A.IV.d.1 (Previous Waiver Period).** The contractors submitted semi-annual complaint summaries to meet the requirements under Objective 3.1. The results of the State's monitoring of these objectives are found in **Attachment B.II (Previous Waiver Period).** Contractors summarized complaints according to type of complaint: access-related, quality-related and other. Access-related complaints are an indicator of possible capacity problems.

The State also calculates enrollee/provider ratios and monitors whether there are changes that could be an indicator of capacity issues. The State calculates FTEs-per-1000 enrollees as of a given point in time (July 1) of each year. Comparing a three-year period (2000-2002), for three of the eight contractors, there was a slight decrease in filled-FTEs-per-1000 enrollees; four maintained their ratios and one contractor had an increase. During analysis and discussion with contractors, the

State determined that the three contractors with decreases had been including substance abuse staff in their FTE reporting in earlier years. They realized this error, and in 2001 and 2002 began reporting only mental health staff. There were also other reporting errors for one of the contractors in the earlier years. The State has provided additional guidance and direction to all contractors on reporting FTE data.

Upcoming Waiver Period
Please indicate which of the following activities the State employs:

a. ___ Periodic comparison of the number and types of Medicaid providers before and after the waiver;

b. ___ Measurement of referral rates to specialists;

c. **X** Provider-to-enrollee ratios;

d. ___ Periodic MCO/PIHP/PAHP reports on provider network;

e. ___ Measurement of enrollee request for disenrollment from a plan due to capacity issues;

f. **X** Tracking of complaints/grievances concerning capacity issues;

g. ___ Geographic Mapping (please explain):

h. ___ Tracking of termination rates of PCPs;

i. ___ Review of reasons for PCP termination;

j. ___ Consumer Experience Survey, including persons with special needs;

V. Coordination and Continuity of Care Standards

Upcoming Waiver Period – Check any of the following that the State requires of the MCO/PIHP/PAHP.

a. **X** Primary Care and Coordination

1. ___ [Required] Implement procedures to deliver primary care to and coordinate health care service for all enrollees.

Not applicable–This is a behavioral health care carve-out which does not provide primary care services.

2. ___ [Required] Ensure each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity who is primarily responsible for coordinating the enrollee's health care services.

   Not applicable–This is a behavioral health care carve-out which does not provide primary care services.

3. __ [Required] Coordinate the services the MCO/PIHP/PAHP furnishes to the enrollee with services the enrollee receives from any other MCO/PIHP/PAHP.

4. **X** [Required] Ensure that in the process of coordinating care, each enrollees' privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

5. **X** The plan is a PHIP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the primary care requirements of 42 CFR 438.208. Please explain.

   The PMHP contract with the contractors contains the following provisions: Medicaid Prepaid Mental Health Plan (PMHP) enrollees may also be enrolled in another managed care plan, such as an MCO or primary care physician program, that will be responsible for directing the physical health needs of the individual. The PMHP contractors are required to coordinate the provision of covered mental health services with the enrollees' MCO or primary care physician. In such cases, the contractors are responsible for all the covered mental health services required by the enrollee.

b. ___ Additional services for enrollees with special health care needs.

1. ___ [Required] Identification. The State has a mechanism to identify persons with special health care needs to MCOs, PHIPs, and PAHPs, as those persons are defined by the State. Please describe:

2. ___ [Required] Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Please describe:

3. ___ [Required] Treatment Plans. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

   (a) ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists who care for the enrollee;

   (b) ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan);

   (c) ___ In accord with any applicable State quality assurance and utilization review standards;

   (d) ___ [Required] Direct access to specialists. If treatment plan or regular care monitoring is needed, MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists for enrollee's condition and identified needs.

   (e) **X** The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 43 CFR 438.208.

   The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 43 CFR 438.208.

   The PMHP is a behavioral-health carve-out; and therefore, by definition, all enrollees who seek mental health services have individualized (special) needs depending on diagnosis and presenting situation. When enrollees seek mental health treatment, they receive a comprehensive mental health evaluation by a licensed mental health therapist who by state law can diagnose and prescribe treatment. If mental health services are clinically indicated, then they receive the needed services which are based on a clinical

treatment plan. The therapist and client jointly develop the individualized treatment plan.

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a. ___ [Required for all elements checked in the previous waiver submission] Please include the results from monitoring continuity and coordination of care in the previous two-year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in the 1995 preprint; item B.VI Upcoming Waiver Period, 1999 Renewal Waiver Preprint]. Summarize items from monitoring plan.

b. **X** [Required for all elements checked in the previous waiver submission if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM, or MCO programs and PIHP/PAHP providers were educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems were identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PIHP/PAHP providers. Please describe how this issue was addressed in the PIHP/PAHP program.

The PMHP contract requires PMHPs to educate other physicians if requested to do so. (See #2 below.)

The onus is on physicians/HMOs to ask their local mental health center for inservice if needed. However, two urban PMHP contractors initiated inservices for local physicians and pediatricians and invited all physicians in their communities. This was an exemplary proactive attempt to educate general practitioners, pediatricians, etc.

As far as coordination between the PMHPs and other groups, the Division of Health Care Financing's contracts with the PMHPs require the following:

1. The contractors will provide access to a coordinated, comprehensive, and continuous array of needed services through coordination with other appropriate entities.

2. Upon request, the contractors will educate MCOs and primary care physicians on the diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.

3. The contractors will coordinate the provision of inpatient mental health services for foster care children with the Utah Department of Human Services' representative.

4. The contractors will coordinate the provision of mental health services for Children with Special Health Care Needs with the Utah Department of Health, Bureau of Children with Special Health Care Needs (CSHCN) when these children are referred by CSHCN. CSHCN includes the Child Development Clinic (CDC), Adaptive, Behavioral, Learning, and Evaluation Clinic (ABLE), Specialty and Pediatric Clinics held at the local health departments, Fostering Healthy Children Program, and the Baby Watch Early Intervention Program. Children with special health care needs often have mental health, behavioral, and medical issues that require a collaborative partnership between the two agencies in diagnosing and treating the child. The contractors will provide outreach to children and families referred by CSHCN when they break/cancel mental health appointments. The contractors will document the outreach efforts.

5. The contractors will also coordinate mental health services for Children with Special Health Care Needs with the services of other agencies (e.g., substance abuse, public health department, transportation, home and community-based waiver providers, developmental disabilities providers, schools, IDA programs and child welfare) and with families, caregivers, and advocates. (CMS Special Needs Criteria)

6. The contractors will provide assistance, including referrals, to enhance enrollee's access to housing, vocational, or other ancillary services.

The PMHPs' 2001 quality improvement study for adult Medicaid recipients focused on how well they were evaluating enrollees seeking mental health treatment for co-occurring substance abuse issues. Seven of the nine contractors are also under contract with the local county substance abuse authority to provide substance abuse services in that county. The primary purpose of the study was to obtain the percentages for identification of these dual-diagnosis clients, with a secondary purpose of focusing on screening, identification, diagnosis, referral, and treatment of this population of clients. All contractors report they now have better screening methods in place as a result of this statewide study focus.

c. **X** [Required if this is a PIHP/PAHP mental health, substance abuse, or

developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees were monitored in this waiver program.

Pharmacy services are not part of the Prepaid Mental Health Plan.

Upcoming Waiver Period – Please describe how standards for continuity and coordination of care will be monitored in the upcoming two-year period:

a. How often and through what means does the State monitor the coordination and continuity standards checked above in item V.B?

The PMHP contract has an extensive section on coordination of care (see above). In addition, Health Insight (PRO) is currently conducting a study of coordination between Health Plans and PMHPs with the goal of developing a model of coordination. Further, during previous and upcoming onsite reviews, the State has and will continue to inquire as to how the PMHP contractor coordinates with other agencies, providers, etc. All contractors currently coordinate formally with a variety of local agencies, through routinely-held meetings, etc., more with children, as there are more agencies focused on children's needs and services. This is in addition to coordination at the individual client level. At the client level, the case manager, if the individual qualifies for targeted case management, or the therapist and another agency/provider coordinate as needed, on a case-by-case basis.

b. Specify below which providers are excluded from the capitated waiver and how the State explicitly requires the MCO/PIHP/PAHP to coordinate health care services with them:

1. ___ Mental Health Providers (please describe how the State ensures coordination exists):

2. **X** Substance Abuse Providers (please describe how the State ensures coordination exists):

Seven of the PMHPs are also under contract with the local county substance abuse authorities to provide the publicly-funded substance abuse services. Therefore, coordination occurs naturally as substance abuse services are also provided by the mental health center. In the other two areas of the state, one of the PMHP contractors meets routinely with the county substance abuse authority to screen and coordinate referrals back and forth. In the other area of the state, the PMHP contractor and the substance abuse agency under contract with the local substance abuse authority co-lead treatment groups for dually-diagnosed individuals and

also have procedures for referrals. Therefore, in both of these areas, the PMHP contractors and local substance abuse agencies under contract with the substance abuse authorities have close working relationships.

The State ensures this is occurring during site visits as described above in "a."

3. **X** Local Health Departments (please describe how the State ensures coordination exists):

   The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved. Therefore, the local health departments would fall under the "other services" classification.

   The State ensures coordination is occurring during site visits as described above in "a."

4. **X** Dental Providers (please describe how the State ensures coordination exists):

   The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other services. In targeted case management audits, the State has seen evidence of case managers assisting their mentally ill clients access needed dental care.

   The State ensures coordination is occurring during site visits as described above in "a."

5. ___ Transportation Providers (please describe how the State ensures coordination exists):

6. **X** HCBS (1915c) Service (please describe how the State ensures coordination exists):

   The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other services.

The State ensures coordination is occurring during site visits as described above in "a."

7. **X** Developmental Disabilities (please describe how the State ensures coordination exists):

   The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other services.

   The State ensures coordination is occurring during site visits as described above in "a."

8. **X** Title V Providers (please describe how the State ensures coordination exists):

   The contractors coordinate the provision of mental health services for Children with Special Health Care Needs with the Utah Department of Health, Bureau of Children with Special Health Care Needs (CSHCN) when these children are referred by CSHCN. Children seen by CSHCN sometimes have mental health issues requiring treatment. Therefore, the PMHP contractors and CSHCN have developed collaborative partnerships in diagnosing and treating the child.

   The State ensures coordination is occurring during site visits as described above in "a."

9. **X** Women, Infants and Children (WIC) program

   The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other agencies.

   The State ensures coordination is occurring during site visits as described above in "a."

10. **X** Indian Health Services Providers

    The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other agencies.

The State ensures coordination is occurring during site visits as described above in "a."

11. **X** FQHCs and RHCs not included in the program's networks

The PMHPs provide targeted case management to assist eligible clients in the target group to gain access to needed medical, social, educational, and other agencies.

The State ensures coordination is occurring during site visits as described above in "a."

12. **X** Other (please describe):

Schools – All of the PMHPs coordinate with local schools and districts as they determine need for mental health services and where they should best be provided (e.g., onsite at the schools or at the mental health center). Many PMHP contractors provide mental health services onsite at the schools, or transport them to after-school groups at the mental health clinics.

SECTION C. QUALITY OF CARE AND SERVICES

A section 1915(b) Waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, MCO, PIHPs, and PAHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submission will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: – This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a. **X** Summarize the results of or include as an attachment reports from the External Quality Review Organization, results from performance improvement projects, and other monitoring reports from the previous waiver period. Describe any follow-up done/planned to address study findings [item C.I.c in1999 initial preprint; item B.2 in 1995 preprint, item C.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

EQRO- not applicable for this waiver period for PMHPs.

In the State's agreed-upon monitoring plan with CMS for this waiver period, (see **Attachment A.IV.d.1. (Previous Waiver Period)** there were two specific objectives related to quality– Objective 2.1 and Objective 2.2. The Division of Substance Abuse and Mental Health conducted its clinical quality reviews to meet Objective 2.1. Objective 2.2 addresses the PMHP contractors' 2002 Quality Improvement projects. The Division of Substance Abuse and Mental Health's reports summarizing their clinical quality review findings for their State fiscal year 2002 reviews and the PMHP contractors' 2002 Quality Improvement study reports are contained in **Attachment C.I.a (Previous Waiver Period).**

b. ___ Intermediate sanctions were imposed during the previous waiver period. Please describe:

Upcoming Waiver Period – Please check any of the items below that the State requires.

a. **X** [Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy of **Attachment C.I.a** (Upcoming Waiver Period).

As per agreement with Region VIII, State strategy will be submitted by May 30, 2003.

b. **X** [Required] The State must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

c. **X** The State must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as needed.

d. **X** [Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning 8/14/03.

1. Please specify the name of the entity:

   To be determined.

1. The entity type is:
   (a) ___ A Peer Review Organization (PRO).
   (b) ___ A private accreditation organization approved by CMS.
   (c) ___ A PRO-like entity approved by CMS.

   To be determined.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

   When the EQRO regulations become effective March 25, 2004, the State will have in place a contract with an External Quality Review Organization that meets the new EQR requirements and includes the scope of work mandated in the new EQR regulations.

e. **X** The State includes required internal quality assessment and performance improvement (QAPI) standards in its contracts with MCOs and PIHPs.

f. **X** The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through the following mechanisms (check all that apply):

1. ___ Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.

2. **X** [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.

3. **X** Conducts monitoring activities using (check all that apply):

   (a) **X** State Medicaid agency personnel;

   (b) **X** Other State government personnel (please specify):

   Staff from the Division of Substance Abuse and Mental Health in the Utah Department of Human Services.

   (c) ___ A non-State agency contractor (please specify):

4. **X** Other (please specify): EQRO

g. **X** [Required] The State has established intermediate sanctions that it may impose.

h. **X** [Required] The State has standards in the State QAPI, at least as stringent as those required in 42 CFR 438 Subpart D for access to care, structure and operations, and measurement and improvement.

II. Access Standards

Coverage and Authorization Services

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]
Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/overutilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint, item C.II Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved

by CMS as part of the two-year waiver extension. This plan did not include Coverage and Authorization Services as a monitoring topic. Please refer to **Attachment A.IV.d.1 (Previous Waiver Period)** to review the approved monitoring plan.

Upcoming Waiver Period – Please check any of the following processes and procedures that the State requires to ensure that MCOs, PIHPs, and/or PAHPs meet coverage and authorization requirements.

Contracts with MCOs, PIHPs, and PAHPs:

a. **X** [Required] Identify, define and specify the amount, duration, and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.

b. **X** **[**Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

c. **X** [Required] Include a definition of "medically necessary services". This definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

"Medically Necessary Services" means any mental health service that is necessary to diagnose, correct or ameliorate a mental illness or condition, or prevent deterioration of that condition or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

d. **X** [Required] Include written policies and procedures for the processing of requests for initial and continuing authorizations of services.

e. **X** [Required] Require that the MCO, PHIP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

f. **X** [Required] Require that the MCO, PIHP, and PAHP consult with the requesting provider when appropriate.

g. **X** [Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be

made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

h. **X** [Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established time frames that may not exceed 14 calendar days. The time frame may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

i. **X** [Required] Require that the MCO, PIHP, or PAHP make an expedited authorization decision no later than three working days after receipt of the request for service. The time frame may be extended up to 14 days if the enrollee requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

j. ___ Other (please describe):

III. Structure and Operation Standards

Provider Selection

Previous Waiver Period
[Required for all related items checked in previous waiver request]
Please provide results from State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved by CMS as part of the two-year waiver extension. This plan did not include Provider Selection as a monitoring topic. Please refer to **Attachment A.IV.d.1 (Previous Waiver Period)** to review the approved monitoring plan.

Upcoming Waiver Period
The State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. Please check any of the following processes that the State includes in its policy.

a. **X** [Required] Each MCO, PIHP, PAHP must develop and implement a documented process for selection and retention of providers.

b. **X** [Required] Each MCO, PIHP, PAHP must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated.

c. **X** Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

d. **X** Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1. **X** Initial credentialing

2. ___ Performance indicators, including those obtained through the following (check all that apply):

(a) ___ The quality assessment and performance improvement program;

(b) ___ The utilization management system;

(c) ___ The grievance system;

(d) ___ Enrollee satisfaction surveys;

(e) ___ Other MCO/PIHP/PAHP activities as specified by the State.

e. **X** Determine, and redetermine at specified intervals, appropriate licensing/accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State **3 years**.

f. ___ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g. **X** Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h. ___ Other (please describe):

IV. Subcontractual Relationships and Delegation

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]
Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint, item C.IV Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved by CMS as part of the two-year waiver extension. This plan did not include Subcontractual Relationships and Delegation as a monitoring topic. Please refer to **Attachment A.IV.d.1 (Previous Waiver Period)** to review the approved monitoring plan.

Upcoming Waiver Period
Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs, PIHPs, and PAHPs oversee and are accountable for any delegated functions.

Where any functions are delegated by MCOs, PIHPs, or PAHPs, the State Medicaid Agency:

a. ___ Reviews and approves (check all that apply):

1. ___ All subcontracts with individual providers or groups;

2. ___ All model subcontracts and addendum;

3. ___ All subcontracted reimbursement rates;

4. ___ Other (please describe):

b. **_X_** [Required] Monitors to ensure that MCOs/ PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

c. **_X_** **[**Required] Requires agreements to be in writing and to specify the delegated activities.

d. **_X_** [Required] Requires agreements to specify reporting requirements.

e. **X** [Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

f. **X** [Required] Ensures that MCOs, PIHPs, and PAHPs monitor the performance of the entity on an ongoing basis.

g. **X** [Required] Monitors to ensure that MCOs, PIHPs, and PAHPs formally review the entity's performance according to a periodic schedule established by the State.

h. ___ [Required] Ensures that MCOs, PHIPs, and PAHPs retain the right to approve, suspend, or terminate any provider when they delegate selection of providers to another entity.

Not applicable – PMHPs do not delegate selection of providers to another entity. They hire their own staff and enter into subcontracts with other community practitioners who are not employees of the mental health center.

i. **X** [Required] Requires MCOs, PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.

j. ___ Other (please explain):

V. Measurement and Improvement Standards

Practice Guidelines

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]
Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint].

To evaluate the quality and appropriateness of services provided to Medicaid clients in State FY 2002, the Division of Substance Abuse and Mental Health in the Department of Human Services conducted clinical reviews of a sample of Medicaid adult clients and Medicaid child clients enrolled with each contractor to evaluate clinical care against the Utah Public Mental Health System Preferred Practice Guidelines.
(See the reports in **Attachment C.I.a (Previous Waiver Period.)**

Upcoming Waiver Period – Please check any of the processes and procedures from the following list that the State requires to ensure that MCOs, PIHPs, and PAHPs adopt and disseminate practice guidelines.

a. **X** [Required] Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

b. **X** [Required] Guidelines consider the needs of the MCO's, PIHP's, or PAHP's enrollees;

c. **X** [Required] Guidelines are developed in consultation with contracting health professionals;

d. **X** [Required] Guidelines are reviewed and updated periodically;

e. **X** [Required] Guidelines are disseminated to all affected providers, and, upon request to enrollees and potential enrollees;

f. **X** [Required] Guidelines are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas;

g. ___ Other (please explain):

Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a. ___ [Required for all elements checked in the previous waiver submission] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in the 1999 initial preprint; relevant sections in the 1995 preprint, item C.VII Upcoming Waiver Period, 1999 Waiver Renewal Preprint]. Please break down monitoring results by subpopulations if available.

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved by CMS as part of the two-year waiver extension. This plan did not include the contractors' Quality Assessment and Performance Improvement (QAPI) plans and activities as a monitoring topic. Please refer to **Attachment A.IV.d.1 (Previous Waiver Period)** to review the approved monitoring plan.

b. **X** The State or its MCOs and PIHPs conducted performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two-year period.

Please refer to **Attachment C.I.a (Previous Waiver Period)** for copies of the contractors' 2002 quality improvement study reports which summarize the topics, findings, and strategies and activities to be implemented to achieve and sustain improvement over time.

Upcoming Waiver Period – The State must require that each MCO and PIHP have an ongoing QAPI for the services it furnishes to its enrollees.

a. **X** [Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes:

1. **X** The MCO's and PIHP's performance on the standard measures on which it is required to report.

2. **X** The results of each MCO's and PIHP's performance improvement projects.

b. **X** Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs:

Each MCO and PIHP must have:

1. **X** A policymaking body which oversees the QAPI;

2. **X** A designated senior official responsible for program administration and documentation of Quality Improvement committee activities;

3. ___ Active participation by providers and consumers;

4. **X** Ongoing communication and collaboration among the Quality Improvement policymaking body and other functional areas of the organization;

5. ___ Other (please describe):

c. **X** [Required] Each MCO and PIHP must have in effect mechanisms to detect both underutilization and overutilization of services. Please describe these mechanisms.

Inpatient care– PMHP contractors manage care and ensure appropriate utilization though prior authorization and continued stay reviews. Outpatient care– PMHP contractors have had a requirement in their contract previously that they conduct peer reviews. As part of the peer reviews, they evaluate whether care is clinically appropriate and provided in appropriate amounts. Some contractors also use periodic case staffing to determine if clients need continued services and if so, which services and in what amount. All of these mechanisms are designed to detect and deter underutilization and overutilization

d. ___ [Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to **enrollees with special health care needs.** Please describe these mechanisms:

See C.V.b. 3(e) and the paragraph below that section. Because contractors are required to provide a mental health evaluation to any enrollee seeking diagnosis or treatment services, it is unnecessary to designate "special population" categories.

e. **X** [Required] Each MCO and PIHP must measure and report to the State its performance, using standard measures required by the State. Please list or attach the standard measures currently required.

The PMHP contractors will be required to submit annual reports documenting adherence to the performance standards for providing first face-to-face services to new clients (Medicaid enrollees) seeking services. (See Section B.I.b.6. for description of the performance standards for emergent, urgent and non-urgent care.)

Performance Improvement Projects

f. **X** [Required] Each MCO and PIHP must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

g. **X** Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

h. **X** [Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

Please list or attach the projects currently planned for each year of the waiver period either at a state or plan level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

Please refer to **Attachment C.V.h (Upcoming Waiver Period)** for the study workplans for the clinical and non-clinical studies planned for 2004. All of the contractors will conduct the same non-clinical study, and eight of the nine will conduct the same clinical study while one contractor chose a separate topic for its clinical study. The 2005 study topics will be selected toward the end of 2004. The contractors have previously selected topics just prior to the start of their studies so that the topics are relevant to current issues.

i. **X** [Required] Each MCO and PIHP must measure performance using objective quality indicators.

j. **X** [Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.

k. **X** [Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

l. __ Each MCO and PIHP must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

m. **X** MCOs or PIHPs are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

n. ___ Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

o. ___ Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

p. ___ Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

q. ___ Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

r. ___ Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's and PIHP's enrolled Medicaid population.

s. ___ Each MCO and PIHP must use benchmark levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

t. ___ Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

u. ___ Other (please describe):

VI. Health Information Systems

Previous Waiver Period
[Required for all elements checked in the previous waiver submission] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

The contractors participate in a Division of Substance Abuse and Mental Health-sponsored Outcomes Project. The contractors administer outcomes surveys to new clients, including Medicaid enrollees, at time of intake and at day 60. The raw data are submitted periodically to the Division of Substance Abuse and Mental Health for compilation and analysis. The data are compiled on a fiscal-year basis. The Outcomes Project just recently finalized the children's outcomes instrument to be used statewide. Therefore, a children's outcomes report is not yet available; children's outcomes data will be included in the State FY 2004 report. The Division analyzes Medicaid clients' outcomes separately from clients with other funding sources. The Division of Substance Abuse and Mental Health's reports on the adult Outcomes Project for state FY 2001 and FY 2002 are in **Attachment C.VI (Previous Waiver Period).**

Upcoming Waiver Period
Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs and PIHPs maintain a health information system

that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program.

The State requires that MCO and PIHP systems:

a. **X** [Required] Provide information on:
   1. ___ Utilization,
   2. **X** Grievances and appeals,
   3. Disenrollment for reasons other than loss of Medicaid eligibility.

b. **X** [Required] Collect data on enrollee and provider characteristics as specified by the State.

c. ___ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PIHP is capable of (please check all that apply):

   1. ___ [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees;

   2. ___ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors;

   3. ___ [Required] Verifying the accuracy and timeliness of data;

   4. ___ [Required] Screening data for completeness, logic and consistency;

   5. ___ [Required] Collecting service information in standardized formats to the extent feasible and appropriate;

   6. ___ Other (please describe):

d. **X** Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

   1. ___ Health services (please specify frequency and provide a description of the data and/or content of the reports);

   2. **X** Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports);

The contractors participate in a Division of Substance Abuse and Mental Health-sponsored Outcomes Project. The contractors administer outcomes surveys to new clients, including Medicaid enrollees, at time of intake and at day 60. The raw data are submitted periodically to the Division of Substance Abuse and Mental Health for compilation and analysis. The data are compiled on a fiscal-year basis.

3. **X** Encounter Data (please specify frequency and provide a description of the data and/or content of the reports):

   The PMHP contract requires that data for a given quarter be submitted within nine months after the end of the quarter. Data are provided in the CMS 1500 and UB-92 formats and include: name, ID #, diagnosis, date of service, procedure code, number of units, provider ID, charge, and TPL information.

4. Other (please describe and specify frequency and provide a description of the data and/or content of the reports):

e. ___ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.

f. ___ Ensure that information and data received from providers are accurate, timely, and complete.

g. ___ Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

h. ___ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i. ___ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness, and usability of data provided to the State by MCOs/PIHPs.

j. ___ The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate MCOs/PIHPs (i.e., report cards). Please describe:

k. ___ The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e., comparison charts to be used by beneficiaries in the selection of MCOs/PIHPs and/or providers). Please describe:

l. ___ Other (please describe):

SECTION D. COST-EFFECTIVENESS

Assurance (Please initial or check)

X The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer **Randy Baker**

Telephone Number: **(801) 538-6733**

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract

a. ___ Risk-comprehensive (fully-capitated–MCOs, HIOs, or certain PIHPs or PAHPs);
b. X Other risk (partially-capitated–PIHP or PAHP);
c. ___ Non-risk. Please use Section C of the PCCM initial application;
d. ___ Other (please explain):

II. Member Months: Attachment D.II.

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost-effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which were used in setting capitation rates under the waiver. The number and distribution of rate cells will vary by State. If the State used different cells in Years 1 and 2 than in Years 3 and 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submission, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

Population in base-year data:

1. **X** Base-year data is from the same population as to be included in the waiver;

2. **X** Base-year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation that supports the conclusion that the populations are comparable.)

III. Without Waiver Data sources and Adjustments: Attachment D.III

Purpose: To explain the data sources and reimbursement methodology for base-year costs.

To identify adjustments which must be made to base-year costs in order to arrive at the UPL for capitated services and the without-waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Attachment D.IV Without Waiver-Cost Development.** Also, it is acceptable to use encounter data or managed care experience to develop with-waiver costs or set capitated rates (see Section D.V). At this time, it is not acceptable to use experience data to develop without waiver costs.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Previous Waiver Period

During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. The differences were:

Please note the date of any methodology change and explain any methodology changes in this preprint.

Upcoming Waiver Period – For all three subsets of adjustments (Without-Waiver Response required, Optional, and With-Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submissions by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Sections 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

1. **X** We assure CMS that DSH payments are excluded from base-year data;

2. **X** We assure CMS that DSH payments are excluded from adjustments;

3. ___ Other (please describe):

b. Incurred but not Reported (IBNR). Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

1. ___ IBNR adjustment was made. Please indicate the number of years used as basis _____;
   (a) ___ Claims in base-year data source are based on date of service;
   (b) ___ Claims in base-year data source are based on date of payment;

2. **X** IBNR adjustment was not necessary (please explain):

   Premiums apply to PMHP services cost; pharmacy FFS is real time.

Methodology:

1. ___ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period;

2. ___ Other (please describe):

c. Inflation. This adjustment reflects the expected inflation in the FFS program between the Base Year and Year 1 and 2 of the waiver. Inflation adjustments may

be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.

Basis:

1. **X** State historical rates;

   (a) Please indicate the years on which the rates are based: Inflation base years **FY 02**;
   (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

   Projection based on percentages expected/budgeted for eligibility

2. ___ Other (please describe):

d. Third-Party Liability (TPL). This adjustment should be used only in the State will not collect and keep TPL payments for post-pay recoveries. If the MCO/PHP will collect and keep TPL, then the Base-Year costs should be reduced by the amount to be collected.

Basis and Methodology:

1. **X** No adjustment was necessary;

2. ___ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database;

3. ___ State collects TPL on behalf of MCO/PHP enrollees;

4. ___ The State made this adjustment;

5. ___ Post-pay recoveries were estimated and the base-year costs were reduced by the amount of TPL to be collected by MCOs/PHPs;

6. ___ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment. This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of

the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

Not applicable.

1. ___ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without-waiver costs, but not included in the MCO/PHP rates, base-year UPL costs, but not included in the MCO/PHP rates, base-year UPL costs, or adjustments;

2. ___ Other (please describe):

f. Payments/Recoupments not Processed through MMIS. Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

Not applicable.

1. ___ Payments outside of the MMIS were made. Those payments include (please describe):

2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3. ___ The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor. Rebates that States receive from drug manufacturers should be deducted from UPL base-year costs if pharmacy services are included in the capitated base. If the base-year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base-year costs by this percentage. States may want to make separate adjustments for prescription versus over-the-counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population;

2. **X** The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not describe drugs that are paid for by the State in FFS;

3. ___ Other (please describe):

Optional Adjustments

a. Administrative Cost Calculation. The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these costs include per-claim claims-processing costs, additional per-record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

1. ___ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to _____ percent of FFS service costs;

2. **X** The State has chosen not to make adjustment;

3. ___ Other (please describe):

Methodology:

1. ___ Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members;

2. **X** Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell;

3. ___ Other (please describe):

b. Copayment Adjustment. This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

1. ___ Claims data used for UPL development already included copayments and no adjustment was necessary;

2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program;

3. ___ The State has chosen not to make adjustment;

4. **X** Other (please describe):

Co-payment does not apply to PMHP.

c. Data Smoothing Calculations for Predictability. Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost-catastrophic claims.

Basis and Methodology:

1. ___ The State made this adjustment (please describe):

2. **X** The State has chosen not to make adjustment;

d. Investment Income Factor. This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of service.

1. ___ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided;

2. **X** The State has chosen not to make adjustment;

3. ___ Other (please describe):

e. PCCM Case-Management Fee Deduction. When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1. ___ PCCM claims data were used to create capitated UPLs and management fees were deducted;

2. **X** This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees;

3. ___ Other (please describe):

f. Pooling for Catastrophic Claims. This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1. ___ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization;

2. **X** The State has chosen not to make adjustment;

3. ___ Other (please describe):

g. Pricing. These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1. ___ Expected State Medicaid FFS fee schedule increases between the base and rate period;

2. **X** The State has chosen not to make FFS price increases in the managed care rates;

3. ___ Changes brought about by legal action (please describe):

4. ___ Changes in legislation (please describe):

5. Other (please describe):

h. Programmatic/Policy Changes. These adjustments should account for any FFS programmatic changes that are not cost-neutral and affect the UPL.

Basis and Methodology:

1. ___ The State made this adjustment (please describe):

2. **X** The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

i. Regional Factors Applied to Small Populations. This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

Methodology:

1. ___ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out side fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget-neutral for each region and State;

2. **X** The State has chosen not to make adjustment;

3. ___ Other (please describe):

j. Retrospective Eligibility. States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PHPS will not incur costs associated with retrospective eligibility because capitated eligibility is prospective.

Basis and Methodology:

1. ___ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed;

2. **X** The State has chosen not to make adjustment because it was not necessary given the State's enrollment process;

3. ___Other (please describe):

k. Utilization. This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years 1 and 2 of the waiver.

1. **X** The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors;
2. ___ The State has chosen not to make adjustment;
3. ___ Other (please describe):

l. Other Adjustments, including but not limited to guaranteed eligibility and risk-adjustment. If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, CMS expects States to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology.

With Waiver Cost Adjustments

a. Reinsurance or Stop/Loss Coverage. Please note whether or not the State will be providing reinsurance or stop/loss coverage. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs.

Basis and Methodology:

1. **X** The State does not provide reinsurance or stop/loss for MCOs/PHPs, but requires MCOs/PHPs to purchase such coverage privately. No adjustment was necessary;

2. ___ The State provides reinsurance or stop/loss (please describe):

b. Incentive/Bonus Payments. This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. Not applicable.

Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PHPs do not exceed the UPL.

c. Other Adjustments (please list and describe the basis and methodology):

IV. Without Waiver Development:

Purpose: To calculate without waiver costs on a PMPM basis.

V. With Waiver Development

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to CMS:

1. **X** The State assures CMS that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the ratesetting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL;

   (a) ___ Rates are set at a percent of UPL;
   (b) ___ Negotiation (please describe):
   (c) **X** Experience-Based (contractor/State cost experience or encounter data) (please describe):
   (d) ___ Adjusted Community Rate (please describe):
   (e) ___ Other (please describe):

2. **X** The rates were set in an actuarially-sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.

3. **X** The State will submit all capitated rates to the CMS RO for prior approval.

b. ___ The State is requesting a 1915(b)(3) waiver in Section A.II.g.2 and will be providing non-State plan medical services.

1. ___ The State will be spending a portion of its savings above the capitation rates for additional services under the waiver;
2. ___ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

SECTION E. FRAUD AND ABUSE

States must promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PIHPs/PAHPs have certain provisions in place.

Previous Waiver Period
[Required for all elements checked in the previous waiver submission] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period. (Reference: items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint, item E.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint)].

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved by CMS as part of the two-year waiver extension. This plan did not include Fraud and Abuse as monitoring topic. Please refer to **Attachment A.IV.d.1 (Previous Waiver Period)** to review the approved monitoring plan.

The contracts between the Division of Health Care Financing and the PMHP contractors require the contractors to abide by Federal and State fraud and abuse requirements including but not limited to referring in writing to the Department of Health all detected incidents of potential fraud or abuse on the part of providers of services to enrollees or to other patients. The contractors also agreed to develop a compliance plan that outlines the contractors' internal processes for identifying fraud and abuse. The contractors have appointed a compliance officer or compliance committee.

During this waiver period, contractors did not refer any incidences in writing to the Department of Health.

Upcoming Waiver Period – Please check all items below which apply, and describe any other measures the State takes.

I. State Mechanisms

a. **X** The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).

b. ___ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State-offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits).

c. ___ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

d. ___ The State has a specific process for informing MCOs/PIHPs/PAHPs of fraud and abuse requirements under this waiver. If so, please describe:

e. ___ Other (please describe):

II. MCO/PIHP/PAHP Fraud Provisions

a. ___ [Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP; e.g., encounter data] MCO/PIHP must certify data as follows:

1. data is accurate, complete, and truthful based on best knowledge, information, and belief;
2. certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO, or CFO;
3. certification is submitted concurrently with data.

b. **X** [Required for MCOs/PIHPs] The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:

1. **X** Written policies that articulate commitment to comply with all applicable Federal and State laws;
2. **X** Designation of compliance officer and committee;
3. **X** Effective training and education for compliance officer and plan employees;
4. **X** Enforcement of standards through well-publicized disciplinary guidelines;
5. **X** Provision for internal monitoring and auditing;
6. **X** Provision for prompt response to detected offense, and corrective action initiative related to MCO/PIHP contract.

c. **X** [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who is, or who is affiliated with, an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

d. ___ The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

SECTION F. SPECIAL POPULATIONS

States may wish to refer to the October 1998 CMS document entitled "Key Approaches to the Use of Managed Care Systems for Persons with Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

[Required for all elements of applicable sections checked in the previous waiver submission] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint; item F.I Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

The Division of Substance Abuse and Mental Health's included Medicaid special needs children (i.e. disabled, foster care, Title V and children receiving adoption subsidy) in their samples for the children's clinical quality reviews. (See **Attachment C.I.a.**)

In their semi-annual complaint summaries, the contractors reported complaints from or on behalf of children in these special needs groups separately from other children. **(See Attachment B.II.)** The State was able to then monitor these complaints specifically to ensure they were resolved successfully or were in the process of being resolved.

Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period – Please check all items that apply to the State.

a. **X** The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or

substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

As per 438.208(a)(2), the State has determined that based on the scope of the entity's services that all individuals enrolled in the PMHP who seek mental health services are considered to have special needs because they are seeking specialized mental health care. The PMHP contract requires the contractors to provide "...at a minimum, all Medically Necessary Covered Services...." In addition, the PMHP contract requires the contractors to provide a mental health evaluation to any Medicaid-eligible individual who is "seeking diagnosis or treatment services." It is therefore unnecessary to further designate "special population" categories.

b. ___ There are special populations included in this waiver program. Please list the populations.

c. ___ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies that serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

d. ___ The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1. ___ Other systems of care (please specify; e.g., Medicare, HRSA title V Grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds);
2. ___ State/local funding sources;
3. ___ Other (please describe):

e. ___ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1. ___ Access to services (please describe):

2. ___ Quality of care (place describe):

3. ___ Coordination of care (please describe):

4. ___ Enrollee satisfaction (please describe):

5. ___ Other (please describe):

f. ___ The State has standards or efforts under way regarding a location's physical American with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

g. ___ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

State Requirements for MCOs/PIHPs/PAHPs

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]
Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint item F.II, Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

Upcoming Waiver Period – Please check all the items that apply to the State or MCO/PIHP/PAHP.

a. ___ The State has required care coordination/case management services the MCO/PIHP/PAHP shall provide for individuals with special health care needs. Please describe by population.

b. ___ As part of its criteria for contracting with an MCO/PIHP/PAHP, the State assesses the MCO's/PIHP's/PAHP's skill and experience level in accommodating people with special needs. Please describe by population.

c. ___ The State requires MCOs/PIHPs/PAHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

d. ___ The State has provisions in contracts with MCOs/PIHPs/PAHPs that allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If not checked, please explain by population.

e. ___ The State collects or requires MCOs/PIHPs/PAHPs to collect population-specific data for special populations. Please describe by population.

f. ___ The State requires MCOs/PIHPs/PAHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.

2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's title V agency for any special needs children who qualify for title V assistance?

g. ___ The State requires MCOs/PIHPs/PAHPs to identify individuals with complex or serious medical conditions in the following ways:

1. ___ An initial and/or ongoing assessment of those conditions;
2. ___ The identification of medical procedures to address and/or monitor the conditions;
3. ___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan;
4. ___ Other (please describe):

h. ___ The State specifies requirements of the MCOs/PIHPs/PAHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

SECTION G. APPEALS, GRIEVANCES, AND FAIR HEARINGS

MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

Internal grievance procedures are optional for PAHPs.

States, MCOs, PIHPs, and PAHPs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- $ informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action;
- $ ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued or reinstated; and
- $ other requirements for fair hearings found in 42 CFR 431 Subpart E.

I. Definitions (MCO/PIHP):

Upcoming Waiver Period

a. **X** [Required] The definition of action in the case of an MCO/PIHP means:
   - **X** Denial or limited authorization of a requested service, including the type or level of service;
   - **X** The reduction, suspension, or termination of a previously authorized service;
   - **X** The denial, in whole or in part, of a payment for a service;
   - **X** The failure to provide services in a timely manner;
   - **X** The failure to act within time frames required by 42 CFR 438.408(b); or
   - ___ For a resident of a rural area with only one MCO, the denial of the enrollee's request to exercise his or her right to obtain services outside the network.

b. **X** Appeal means a request for a review of an action.

c. **X** Grievance means an expression of dissatisfaction about any matter other an action.

d. ___ Please describe any special processes that the State has for persons with special needs.

II. Grievance Systems Requirements (MCO/PIHP):

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submission]
Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to appeals, grievances, and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint; item G.II 1999 Upcoming Waiver Renewal Preprint] Also, please provide summary information on the types of appeals, grievances, or fair hearings during the previous-two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Strategy.

There were no fair hearings during this two-year waiver period. One case did request a pre-hearing telephone conference to address the issues. A private provider wanted to continue seeing a client while the PMHP contractor was concerned about the type of service, duration of treatment, and level of documentation he was providing. It was agreed during the pre-hearing telephone conference that the client would see the private therapist for individual therapy once a month and begin group therapy at the PMHP (in an effort to transition her from what appeared to be excessive and unnecessary individual contacts). They also agreed to educate the provider on their specific documentation requirements. The contractors also summarized complaints received in their semi-annual complaint summaries. (See **Attachment B.II**.)

b. Please mark any of the following that apply:

1. ___ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2. **X** Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.

   Please refer to **Attachment B.II (Previous Waiver Period)** for number, types, and resolution of complaints.

3. ___ There is a consumer involvement in the grievance process. Please describe.

Upcoming Waiver Period – Please check requirements in effect for MCO/PIHP grievance processes.

a. Required Appeals, Grievances, and Fair Hearings Elements for MCOs/PIHPs:

1. **X** MCOs/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.

2. **X** An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits:
   (a) __ direct access without first exhausting the MCO/PIHP grievance process;
   (b) **X** exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed.

3. **X** Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 CFR 431 Subpart E.

4. **X** The State specifies a time frame that is no less than 20 days and does not exceed 90 days from the date of action for the enrollee to request an appeal or fair hearing. Specify the time frame **30 calendar days from date of action.**

5. ___ [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State _____.

6. **X** The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.

7. **X** The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PIHPs to acknowledge complaints and grievances, please specify:

8. **X** The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).

9. **X** The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decisionmaking.

10. **X** The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.

11. **X** The MCO/PIHP ensures the special requirements for appeal; i.e., on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.

12. **X** Time frames for resolution:

    (a) **X** Grievances are resolved within **45 calendar** days (may not exceed 90 days from date of receipt by MCO/PIHP).

    (b) **X** Standard appeals are resolved in **15 calendar** days (may not exceed 45 days from date of receipt by MCO/PIHP).

    (c) **X** Expedited appeals are resolved in **3 working** days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).

13. **X** Time frames for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).

14. **X** The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d-e).

15. **X** The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR 438.408(f).

16. **X** The MCO/PIHP maintains an expedited review process for appeals when it is determined that the standard resolution time frame could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.10.

17. ___ The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g., independent State review mechanism).

18. **X** MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.

19. **X** The State reviews information on each MCO's/PIHP's appeals as part of the State quality strategy.

20. ___ The State and/or MCO/PIHP have ombudsman programs to assist enrollees in the appeals, grievance, and fair hearing process.

21. ___ Other (please specify):

III. PAHP Requirements

a. ___ [Optional] PAHPs have an internal grievance system. Please describe.
b. ___ [Required] PAHP enrollees have access to the State fair hearing process.

SECTION H. ENROLLEE INFORMATION AND RIGHTS

This section describes the process for informing enrollees and potential enrollees about the waiver program, and protecting their rights once enrolled. Marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.IV.a).

I. Information – Understandable; Language; Format

Previous Waiver Period
[Required] Please provide copies of the brochure and informational materials for potential enrollees explaining the program and how to enroll.

Please see copies of *Exploring Medicaid* and the PMHPs' Medicaid brochures in **Attachment H.I (Previous Waiver Period).**

Upcoming Waiver Period – This section describes how the State ensures information about the waiver program understandable to enrollees and potential. Please check all the items that apply to the State or MCO/PIHP/PAHP. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. **X** [Required] The State will ensure that materials provided to potential enrollees and enrollees by the State, the enrollment broker, and the MCO/PIHP/PAHP are in a manner and format that may be easily understandable.

b. **X** Potential enrollee and enrollee materials will be translated into the prevalent languages listed below (if the State does not require written materials be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):
1. ___ Spoken by significant number of potential enrollees and enrollees;
2. **X** The languages spoken by approximately **5** percent or more of the potential enrollee/enrollee population;
3. ___ Other (please explain):

c. **X** [Required] Oral translation services are available to all potential enrollees and enrollees, regardless of languages.

d. **X** [Required] The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The State produces and maintains its *Exploring Medicaid* which explains Utah's managed care programs. This is given to all new Medicaid enrollees at time of Medicaid enrollment.

e. **X** [Required] Each MCO/PIHP will have a mechanism in place to help potential enrollees and enrollees understand the requirements and benefits of the plan. Please describe.

The contract between the Division of Health Care Financing and the PMHPs requires the contractors to produce an informational brochure that explains in clear terms the benefits available to enrollees, including the scope of benefits, the availability of interpretive services, clinic locations, any toll-free telephone numbers, how to obtain emergency care including telephone numbers, the contractor's and enrollee's responsibilities with respect to out-of-area emergency services, and using providers outside the contractor's network of preferred providers, unauthorized care, hospital admission procedures, non-covered services, complaints and grievance procedures, and other information necessary to assist enrollees in gaining access to services covered by the contract. This brochure is given along with *Exploring Medicaid* at the time of enrollment, and if enrollees seek mental health services, at the time of intake with the PMHP contractor.

The contractors are required to write all enrollee information, instructional and educational materials, including the brochure in a format that is easily understood.

f. **X** The State's and MCO's/PIHP's/PAHP's information materials are available in alternative formats that take into consideration the special needs of those, for example, with visual impairments.

II. Potential Enrollee Information

Upcoming Waiver Period – This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not checked, please explain why.

a. ___ [Required] Timing. The State or its contractor will provide the required information:

1. At the time the potential enrollee becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory program;

2. Within a time frame that enables the potential enrollee to use the information in choosing among available MCOs/PIHPs/PAHPs.

b. Content. The State and/or its enrollment broker provides the following information to potential enrollees:

1. ___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities;

2. ___ An initial notification letter;

3. ___ A form for enrollment in the waiver program and selection of a plan;

4. ___ Comparative information about plans;

5. ___ Information on how to obtain counseling on choice of MCOs/PHPs;

6. ___ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method):

7. ___ A health risk assessment form to identify conditions requiring immediate attention;

8. ___ [Required] General information about:
   (a) ___ Basic features of managed care;
   (b) ___ Which populations are excluded from enrollment, subject to mandatory enrollment; or eligible for voluntary enrollment;
   (c) ___ MCO/PIHP/PAHP responsibilities for coordination of care;

9. ___ [Required] Specific information about each MCO/PIHP/PAHP (a summary may be provided, but State must provide detailed information upon request):
   (a) ___ Benefits covered;
   (b) ___ Cost sharing (if any);
   (c) ___ Service area;
   (d) ___ Names, locations, telephone numbers, and non-English language(s) spoken by contracted providers, and identification of providers not accepting new patients (at a minimum: primary care physicians, specialists, and hospitals);

(e) ___ Benefits available under State Plan but not covered by contract, including how and where to obtain; cost sharing; and how transportation provided. For counseling/referral service that MCO/PIHP/PAHP does not provide, State must provide information;

10. ___ Other items (please explain):

III. Enrollee Information

a. The State has designated the following as responsible for providing required information to enrollees:

1. **_X_** the State or its contractor;
2. **_X_** the MCO/PIHP/PAHP.

b. _X_ [Required] Timing. The State, its contractor, or the MCO/PIHP/PAHP must provide the information to enrollees as following:

1. **_X_** For new enrollees, all required information within a reasonable time after the MCO/PIHP/PAHP receives notice of beneficiary's enrollment.

2. **_X_** For existing enrollees:
   (A) State must notify of disenrollment rights at least annually, and if there is a lock-in, by no less than 60 days before the start of each enrollment;
   (B) Notify all enrollees of right to request and obtain required information at least once a year;
   (C) Provide written notice of any significant change in required information;
   (D) MCO/PIHP/PAHP will make a good faith effort to give written notice of termination of contracted provider within 15 days after receipt of termination notice, to each enrollee who received primary care from, or was seen on regular basis by, terminated provider.

c. _X_ [Required] Content. The State, its contractor, or the MCO/PIHP/PAHP will provide the following information to all enrollees:

1. **_X_** Benefits covered;
2. ___ Cost sharing;

3. **X** Individual provider information – name, location, telephone, non-English languages, not accepting new patients (for MCO, PIHP, PAHP must include at a minimum PCPs, specialists, hospitals);
4. ___ Benefits available under State Plan but not covered under contract, including conscience clause;
5. **X** Restrictions on freedom of choice within network;
6. **X** Enrollee rights and protections;
7. **X** Procedures for obtaining benefits;
8. **X** Extent to which benefits may be obtained out of network (including family planning);
9. **X** Which and how after-hours and emergency care are provided including:
    - Definition of emergency medical condition, emergency services, and post-stabilization services;
    - No prior authorization for emergency services;
    - Procedures for obtaining emergency services;
    - Location of emergency settings;
    - Right to use any hospital for emergency care.
10. **X** Post-stabilization rules;
11. ___ Referral for specialty care;
12. ___ [Optional] PAHP grievances procedures if available (if PAHP makes available, need to describe to enrollees);
13. **X** State fair hearing rights:
    - Right to hearing;
    - Method for obtaining hearing;
    - Rules governing representation at hearing;
14. **X** MCO/PIHP grievance, appeal, and fair hearing procedures and time frames, including:
    - Right to file grievances and appeals;
    - Requirements and time frames for filing grievance or appeal;
    - Availability of assistance in filing process;
    - Toll-free number to file grievance or appeal by phone;
    - Continuation of benefits, including:
        - Right to have benefit continued during appeal or fair hearing;
        - Enrollee may have to pay for cost of continued services if decision is adverse to enrollee;
    - Any appeal rights State makes available to provider;
15. **X** Advance directives;
16. ___ Physician incentive plan information upon request;
17. **X** Information on structure/operation of plan, upon request.

IV. Enrollee Rights

Upcoming Waiver Period – Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PIHPs/PAHPs protect enrollee rights. The State requires:

a. **X** [Required] MCOs/PIHPs to have written policies with respect to enrollee rights;

b. **X** [Required] Ensures staff and affiliated providers take those rights into account when furnishing services to enrollees;

c. **X** [Required] Ensure compliance with any applicable Federal and State laws that pertain to enrollee rights (such as Civil Rights Act, Age Discrimination Act, Rehabilitation Act, and American with Disabilities Act);

d. **X** [Required] The State will assure that each enrollee has the following rights:

1. **X** Receive information on his/her managed care plan;
2. **X** Be treated with respect, consideration, or dignity and privacy;
3. **X** Receive information on treatment options;
4. **X** Participate in decisions regarding care, including right to refuse treatment;
5. **X** Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, retaliation;
6. **X** If privacy rules apply, request and receive copy of medical record and request amendments;
7. **X** Be furnished health care services in accordance with access and quality standards.

e. **X** [Required] The State will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO/PIHP/PAHP or its providers treat the enrollee.

f. ___ Other (please describe):

V. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period
[Required for all elements checked in the previous waiver submission]
Please include the results from monitoring MCO/PIHP/PAHP enrollee information and rights in the previous two-year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint; item H.IV Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

As part of the renewal process during the previous waiver period, State staff in conjunction with CMS developed an Operating and Monitoring Plan outlining the objectives to be monitored during the waiver period. This monitoring plan was approved by CMS as part of the two-year waiver extension. This plan did not include Enrollee Information and Rights as a monitoring topic. Please refer to **Attachment A.IV.d.1 (Previous Waiver Period)** to review the approved monitoring plan.

Upcoming Waiver Period – Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a. ___ The State tracks disenrollments and reasons for disenrollments or requires MCO/PIHPs/PAHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b. **X** The State will approve enrollee information prior to its release by the MCO/PIHP/PAHP.

c. **X** The State will monitor MCO/PIHP/PAHP enrollee materials for compliance in the following manner (please describe):

As part of the contract with the PMHPs, the brochure must be revised as needed to ensure information is up to date or as required by DHCF. The contractors must submit a draft of the updated brochure to DHCF for review and approval before printing and distributing the revised brochure to enrollees. DHCF will notify the contractors in writing of its approval or disapproval within ten working days after receiving the draft brochure unless DHCF and the contractor agree to another time frame.

The State will review all revisions to contractors' brochures to ensure they include all the new required information.

d. X The State will monitor the MCO's/PIHP's/PAHP's compliance with the enrollee rights provisions in the following manner (please describe):

Review contractors' patient rights statements to ensure they have updated them to include the enrollee rights specified in the PMHP contract and in **IV.d.** above (if not already included)